1.) **Return New Employee Enrollment Form if you are not in plan and wish to participate.**
2.) **Return this form if you are currently enrolled and wish to change your coverage.**

compbenefits vision dental

Dental Plan Change Form

Effective Date: _____
Employee #: _____

Employee's Name: Last Name	First	M.I.	Employee's Social Security #:

Employer Name: Shelby County Government

Employee Changes - Please Complete The Appropriate Items Below

CHANGE OF ADDRESS

Street: _____ Apt #: _____
City: _____
State: _____ Zip Code: _____

PLEASE SELECT ONE

☐ Employee ☐ Employee + One ☐ Family

CHANGE COVERAGE TO (Check One)

☐ Option I - Basic Managed Care, Prestige 45
☐ Option II - Enhanced Managed Care, Prestige 15
☐ Option III - Elite Preferred 520
☐ Option IV - Elite Preferred 510

SELECT DENTIST FOR OPTION I (PST45) AND II (PST15) ONLY

If you are changing your coverage to the Pre-paid Plan, select a dentist from the list of Participating General Dentists, which is included in your enrollment packet. Write the Dental Facility Number of the dentist you have chosen in the space below. List Facility Number for all Family Members:

CHANGE DEPENDENT COVERAGE

List dependents to be added or deleted:

Last Name	First	M.I.	Relationship	Date of Birth	Sex	Facility #	Add	Delete

CANCEL COVERAGE (Check Box) ☐

Employee's Signature: _____ Date: _____